APPLICATION GUIDANCE
FOR

IMPROVING SYSTEMS OF CARE FOR PREGNANT WOMEN EXPERIENCING DOMESTIC VIOLENCE

CFDA# 93.926J

December 1999

APPLICATION DUE DATE: February 11, 2000

ANTICIPATED DATE OF AWARD: May 1, 2000

Division of Perinatal Systems and Women's Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Department of Health and Human Services

Electronic Access

Application guidance for MCHB programs is available on the MCHB Homepage via World Wide Web at:http://www.mchb.hrsa.gov. Click on the file format you desire, either WordPerfect 6.1 or Adobe Acrobat (The Adobe Acrobat Reader also is available for download on the MCHB Homepage). If you have difficulty accessing the MCHB Homepage via the World Wide Web and need technical assistance, please contact the ***Information Technology Branch at (301)443-8989 or webmaster@psc.gov.***

NOTE: This document is not a complete kit. The necessary forms are enclosed with this document.

Read this entire document carefully before starting to prepare an application.

MCHB
Maternal and Child Health Bureau

HRSA
Health Resources & Services Administration

{ This Page Intentionally Left Blank }

APPLICATION GUIDANCE FOR IMPROVING SYSTEMS OF CARE FOR PREGNANT WOMEN EXPERIENCING DOMESTIC VIOLENCE

TABLE OF CONTENTS

PREFACE

The Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), a leader in protecting the health of our Nation's mothers and their children, is an outgrowth of the Children's Bureau, founded in 1912. For close to 90 years, MCHB or its predecessor has worked towards improving the health and welfare of mothers, infants, children, and youth, and supported a variety of programs, including:

- Family planning and counseling
- Well-child clinics
- Immunizations
- Lead poisoning prevention
- Services for low-income and minority women and children
- Community-based, family-centered services for children with special health care needs
- National or regional projects, as follows:
  - Research
  - Training
  - Hemophilia diagnosis and treatment
  - Genetic screening, counseling, and referral
  - Maternal and child special health improvement projects
  - Ryan White Title IV HIV Program for Children, Youth, Women and Families
  - Emergency medical services for children
  - Infant mortality reduction projects

The MCHB administers national programs on perinatal and women's health with an emphasis on infant mortality reduction. These programs include the Title V Maternal and Child Health Services Block Grant and the Healthy Start Initiative (HSI). The Title V Maternal and Child Health Services Block Grant encompasses a national program of block grants to states to assure mothers (women of childbearing age) and children, especially those with low income or limited availability of health services, access to quality maternal and child health services. The MCHB also sponsors a program of Special Projects of Regional and National Significance (SPRANS) and a program of Community Integrated Service Systems (CISS) to improve the health of the Nation's families and children. The HSI focuses on the need to strengthen and enhance community systems of maternal and infant care and challenges communities to fully address the medical, behavioral and psychosocial needs of women and infants to ensure that all infants have a healthy start in life. This program centers on: (1) the provision of community-based, culturally competent, family-centered, comprehensive perinatal services to women, infants and their families in communities with extremely high rates of infant mortality; and (2) the integration of these services into existing perinatal systems of care. Under Title V, MCHB provides a national focus for leadership in and coordination of Federal, State, local and non-government efforts to

promote healthy births and to define the health problems of women of childbearing age and to explore the impact of the mother's health on other family members. This focus has recently been expanded to explore more directly aspects of women's health within maternal and child health. Specifically, this is accomplished through the development and implementation of initiatives that focus on the role of women's health beyond pregnancy-related issues, to include comprehensive preventive services, e.g., pregnancy prevention, domestic violence, sexually transmitted diseases and HIV prevention, nutrition counseling, smoking cessation programs, and programs to promote positive health behaviors.

In addition, MCHB provides funds through many other vehicles, including research grants designed to broaden the maternal and child health knowledge base for maternal and child health programs or programs for children with special health care needs, training grants that focus on providing leadership training within the various health professions for the provision of comprehensive health care to mothers and children, and skills enhancement of State and local maternal and child health personnel.

All of the MCHB-supported services or projects have as their goals, the development of (1) more effective ways to coordinate and implement existing and new systems of care; (2) leadership for maternal and child health programs throughout the United States; (3) innovative outreach techniques that can identify and deliver appropriate care and preventive education to at-risk populations; (4) a body of knowledge that can be utilized by any part of the maternal and child health community; and (5) significant, fundamental improvement in the lives and health of our Nation's mothers and their children.

This guidance document addresses the specific requirements for development of grant applications for Improving Systems of Care for Pregnant Women Experiencing Domestic Violence. This grant program is funded under Section 301 of the Public Health Service Act (42 U.S. Code 300ff-11 et seq.).

CHAPTER 1 INTRODUCTION

1.1 Program Goal and Background

The goal of this three year demonstration program is to develop and/or enhance systems of care that: (1) identify pregnant women who are experiencing domestic violence and, (2) provide appropriate information, referrals, and linkages to interventions within an identifiable system of care. The intent of this grant initiative is to utilize a systems approach to ensuring that pregnant women who are experiencing domestic violence are not only identified in a sensitive and effective manner but are also directly linked to the network of services they need to improve their health and safety. The nature of the linkage should be such that barriers to access are significantly reduced and women are actively supported in their desire to utilize services within a coordinated, confidential network of medical providers, women's shelters, legal and law enforcement, and other support services.

For the purposes of this guidance, domestic violence occurring around the time of pregnancy is defined as physical, sexual, or psychological/emotional violence, or threats of physical or sexual violence that are inflicted on a woman during the immediate pre-pregnancy, pregnancy, or post-pregnancy periods or any combination of these time frames (Petersen, Saltzman, Goodwin & Spitz, 1998) by someone with whom she has been in an intimate relationship. Pregnancy presents an important window of opportunity to identify domestic violence; the routine frequency of prenatal visits can facilitate a relationship of trust and support between the clinician and her/his client and the opportunity to promote change. The health consequences of domestic violence may include physical injury and disability, and social, emotional and/or economic deprivation and isolation for the woman. In addition, over the last two decades, studies have shown that violence during pregnancy may be associated with adverse pregnancy outcomes including low birthweight and preterm delivery (Petersen, Gazmararian, Spitz, & Rowley, 1997). Recent estimates indicate that approximately 1.8 million women in the United States (3 percent of all women) are severely assaulted by their male partners each year (Petersen, Saltzman, Goodwin & Spitz, 1998). Approximately one quarter of the women in the United States will be abused by a current or former partner sometime during their lives (AMA, 1992).

Pregnancy has been identified as a potential period of increased risk for violence inflicted by intimate partners. Women with an unwanted pregnancy in one study had more than four times the risk of physical violence by a partner compared to women with intended pregnancies. (O'Campo and Baldwin,1999). The prevalence of violence during pregnancy is estimated to range between 0.9% to 20.1% but a number of studies indicate a narrower range of 3.9% to 8.3% (Gazmararian, J., Laxorick, S., Spitz, A., Ballard, T., Saltzman, L., & Marks, J., 1996). Utilizing these figures, it is estimated that of the 3.88 million women in the U.S. who had a live-

birth in 1997, between 151,300 to 322,000 of these women experienced violence during their pregnancy. This indicates that pregnant women are more likely to experience violence than preeclampsia, gestational diabetes, or placenta previa (Petersen, Saltzman, Goodwin & Spitz, 1998).

In an effort to reduce the incidence of abuse and provide more effective help for its victims, the Surgeon General recommended in 1985, that assessment for violence during pregnancy become a routine part of prenatal care (ACOG, 1995). Many national professional organizations have developed recommendations for screening, treatment and referral on domestic violence, particularly around the time of pregnancy. These organizations include The American College of Obstetricians and Gynecologists, the American Medical Association, the American College of Nurse-Midwives, and the American Academy of Family Physicians (Wiist and McFarlane, 1999). Their guidelines and training materials promote the fact that domestic violence occurs across all racial, cultural, and economic groups. Providers need to increase their capacity to address domestic violence with clients by assessing for domestic violence in a brief, sensitive, age- and culturally-appropriate and supportive manner as part of their routine screening and ongoing care during the perinatal period and to effectively intervene and facilitate the woman's access to necessary services. Any interventions must respect the woman's rights in the decision-making process.

Improvements in routine prenatal and postpartum screening and ongoing assessment for domestic violence are only one part of the comprehensive response necessary to develop and/or enhance the system of care. When a victim is identified, counseling activities must take into consideration the dynamics of the battering relationship and the timing of appropriate, confidential interventions such as facilitating access to shelters, legal and law enforcement agencies, and other support services that can effectively address the woman's needs. During the initial prenatal visit, a pregnant women may not be ready or may not feel comfortable to disclose information about domestic violence and/or take action against such violence. Consequently, assessment for domestic violence may be indicated over several perinatal care visits. A recent study by Wiist and McFarlane (1995) found that incorporation of an abuse assessment protocol into the routine procedures of public health clinics increased the assessment, identification, documentation of and referral for violence against pregnant women.

Ensuring that pregnant women anticipate, avoid, cope with, and recover from domestic violence is a complex task that calls for the coordinated efforts of a varied network of community agencies that go beyond those that health and mental health professionals can provide (The Commonwealth Fund, 1998). Each type of agency (medical, women's shelters, counseling and social support, legal, law enforcement) is skilled in different aspects of domestic violence and brings critical expertise of benefit to effectively address domestic violence and must be partners

in the system of care. Non-medical agencies such as women's shelters and advocacy organizations may offer unique insights and knowledge of particular usefulness to the provider who seeks to enhance his/her capacity to effectively assess for and intervene when domestic violence is identified. At a minimum, the medical provider should have a list of referral agencies to share with the victim and she should be made aware of the support services available in the community, such as shelters for battered women, nonresidential counseling services, community resources that can offer financial and emotional support for her and her children, and agencies that can advise her of her legal rights. This referral system should have secure checks and balances to assure that the safety and confidentiality needs of the victim and her family are being met (ACOG, 1995) and that barriers to actually receiving these services are eliminated.

1.2 Program Purpose

The purpose of this demonstration program is to develop and/or enhance comprehensive systems of care that: (1) identify women who are experiencing domestic violence during or around the time of pregnancy through increasing provider capacity to appropriately, sensitively and routinely screen for domestic violence; (2) provide age- and culturally-appropriate intervention information to pregnant women experiencing domestic violence. Such information should include but not be limited to a discussion of domestic violence (e.g. prevalence and significance in pregnancy, resource referral options) and the community's system for linking the woman to a safe environment of medical and support services skilled in the aspect(s) of domestic violence that can intervene to protect the health, safety, and rights of the woman experiencing domestic violence and her unborn infant(s); (3) to the extent possible while preserving their safety and confidentiality, involve women who have experienced domestic violence during pregnancy in the planning and implementation of the system of care; and (4) develop and/or enhance into an effective system, the existing partnerships and linkages between health providers and key community organizations (e.g. safe housing/women's shelters, legal and law enforcement, consumer advocacy, counseling, and social support resources) in the State and community concerned with the needs of women experiencing domestic violence during or around the time of pregnancy. It is <u>essential</u> to preserve the safety (for client, provider, and staff) and confidentially (across and within service agencies) of the woman in all screening and intervention activities.

1.3 Maternal and Child Health Bureau Statements

1.3.1 Healthy People 2000

The Public Health Service (PHS) is committed to achieving the health

promotion and disease prevention objectives of Healthy People 2000, a HRSA-led national activity for setting priority areas. The Division of Perinatal Systems and Women's Health addresses issues relate to the Healthy People 2000 objectives 14.1 through 14.16. Potential applicants may obtain a copy of Healthy People 2000 (Full Report: Stock No. 017-001-00474-0) or Healthy People 2000 (Summary Report: Stock No. 017-001-00473-1) through the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402-9325 (telephone: 202-512-1800). The Healthy People 2010 document will not be available until January 2000.

1.3.2 Smoke-Free Environment

The Maternal and Child Health Bureau strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of all tobacco products. In addition, Public Law 103-227, the *Pro-Children Act of 1994*, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

1.3.3 Electronic Access

Application guidance for MCHB programs is available on the MCHB Homepage via World Wide Web at: http://www.mchb.hrsa.gov. Click on the file format you desire, either WordPerfect 6.1 or Adobe Acrobat (The Adobe Acrobat Reader also is available for download on the MCHB Homepage). If you have difficulty accessing the MCHB Homepage via the World Wide Web and need technical assistance, please contact ***the Information Technology Branch at (301)443-8989 or webmaster@psc.gov.***

1.3.4 Special Concerns

HRSA's Maternal and Child Health Bureau places special emphasis on improving service delivery to women, children, and youth from communities with limited access to comprehensive care. This same special emphasis applies to improving service delivery to children with special health care needs. **In order to assure access and cultural competence, it is expected that projects will involve individuals from the populations to be served in the planning and implementation of the project.** The Bureau's intent is to ensure that project interventions are responsive to the cultural and linguistic

needs of special populations, that services are accessible to consumers, and that the broadest possible representation of culturally distinct and historically under represented groups is supported through programs and projects sponsored by the MCHB.

Cultural competence is defined as a set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment and is achieved over time.

1.3.5 Evaluation Protocol

Evaluation and self-assessment are critically important for quality improvement and assessing the value-added contribution of MCHB/HRSA investments. Consequently, all MCHB discretionary grant projects are expected to incorporate a carefully designed and well planned evaluation protocol capable of demonstrating and documenting measurable progress toward achieving the stated goals. The measurement of progress toward goals should focus on systems, health and performance indicators, rather than solely on intermediate process measures.

The protocol should be based on a clear rationale relating to the identified needs of the target population with grant activities, project goals, and evaluation measures.

A project lacking a complete well-conceived evaluation protocol may not be funded.

1.3.6 Federal Responsibilities

Once the grant is awarded, it is anticipated that some Federal programmatic involvement and consultation may be required with grantees. Federal involvement may include assistance with planning, guidance, and/or provision of technical assistance. Periodic meetings, conferences, and/or communications with the award recipients may be conducted to review mutually agreed upon goals and objectives and to assess progress. The outcome of Federal oversight

activities could lead to adjustments in priority tasks for a project.

{ This Page Intentionally Left Blank }

CHAPTER 2 APPLICATION AND REVIEW PROCESS

2.1 Who Can Apply for Funds

2.1.1 Eligible Applicants

Authorizing legislation and governing programmatic regulations specify eligibility for individual grant programs. For the purposes of this competition, all public or nonprofit organizations, institutions, governments and their agencies are eligible to receive awards. **However, only one application may be submitted per state**. To coordinate the submission of applications within states so that only one application is submitted, contact your state Title V Maternal and Child Health Director (see Appendix I).

2.1.2 Funding Preference

For purposes of this competition, preference will be given to State/Territorial Title V Maternal and Child Health agencies, tribal health agencies or their designees. If the applicant is other than one of these agencies, then the applicant must provide both a specific designation from and evidence of a strong partnership with the State/Territorial Title V or tribal health agency. Non-state MCH applicants without a designation letter from the State Title V director will not be given the same priority for funding as those who include a letter from the State Title V Director designating the applicant as having their State's sole eligibility. The endorsement must include a statement that acknowledges the applicant is using the sole eligibility of the State/Territorial Title V or tribal health agency. For further information, contact the Maternal and Child Health Director in your state.

2.2 Funding and Application Details

A total of $600,000 is available to fund up to four projects with awards up to $150,000 (including indirect costs) per project for the first year. Pending availability of funds and adequate progress, project periods for the grants under this competition will be for three years, starting May 1, 2000 and concluding on April 30, 2003. The first budget period will be for one year, May 1, 2000 to April 30, 2001. The submission of a separate budget page is required for each of the three budget years requested in the application.

Please note that grant funds may only be used to supplement and not supplant other federal and non-federal funds that would otherwise be made available for the project. Grant funds may not be used to replace and reapply other funds elsewhere.

2.2.1 Official Application Kit

Application guidance documents for MCHB programs is available on the MCHB Homepage via World Wide Web at: http://www.mchb.hrsa.gov. Click on the file format you desire, either WordPerfect 6.1 or Adobe Acrobat (The Adobe Acrobat Reader also is available for download on the MCHB Homepage). If you have difficulty accessing the MCHB Homepage via the World Wide Web and need technical assistance, please contact the Information Technology Branch (301) 443-8989.

A hard copy of the official grant application kit (Revised PHS Form 5161-1, approved under OMB clearance number 0937-0189) must be obtained from the HRSA Grants Application Center. The Center may be contacted by telephone: 1-877-477-2123; FAX: 703-351-5341; or E-mail: "hrsa.gac@hrsa.gov".

2.2.2 Letter of Intent to Apply

If you intend to submit an application for this competition, please notify the Division of Perinatal Systems and Women's Health of MCHB by **January 14, 2000** by submitting a Letter of Intent (LOI)**.** The LOI should include the following: (1) name of the organization, address, phone number, contact person and their email address; and (2) State and geographic area proposed to be served. Although not required, the LOI has proven to be very useful to prospective applicants in the event MCHB needs to provide additional guidance regarding the grant application. It would also be appreciated if you would notify the MCHB if you should decide *not* to apply, once you have already submitted an LOI. Send your Letter of Intent to Karen Hench, RN, MS using one of the following communication methods:

Fax (301) 594-0186
E-Mail: khench@hrsa.gov
Mail: Perinatal and Women's Health Branch
Division of Perinatal Systems and Women's Health, MCHB
Attn: Karen Hench

Parklawn Building, Rm. 11A-05, 5600 Fishers Lane
Rockville, Maryland 20857

2.2.3 Application Due Date

The application deadline date is **February 11, 2000**. Applications will be considered as having met the deadline if they are: (1) received on or before the deadline date, or (2) are postmarked on or before the deadline date and received in time for orderly processing and submission to the review committee. No extension of the due date will be granted. (Applicants should request a legibly dated receipt from a commercial carrier or U.S. Postal Service. Private metered postmarks will not be acceptable as proof of timely mailing.) Applicants may contact the HRSA Grants Application Center if confirmation of their application's receipt by the Center is desired.

2.2.4 Mailing Address

All applications should be mailed or delivered to:

HRSA Grants Application Center/CFDA #93.926J
ATTN: Curtis Colston, Grants Management Specialist
1815 N. Fort Myer Drive
Suite 300
Arlington, VA 22209
Telephone: 1-877-477-2123

Grant applications sent to any address other than the above are subject to being returned without further consideration.

2.2.5 Copies Required

Applicants are required to submit one ink-signed original and two copies of the completed application. In addition to the original copy of the Abstract in the application, send a second paper copy and a disk copy of the Abstract in a separate envelope that is included with the grant application. Please indicate the type of software and operating system used (e.g., Word Perfect for Windows or MacIntosh, Word for Windows or MacIntosh) on the envelope and/or disk label.

2.2.6 Applicant Assistance

Applicants may obtain additional information, after reviewing the grant guidance, regarding logistic, administrative, or fiscal issues related to the grant process by contacting:

Curtis Colston, Grants Management Specialist
Maternal and Child Health Bureau, HRSA
Parklawn Building, Room 18-12
5600 Fishers Lane
Rockville, Maryland 20857
Telephone: (301) 443-3438

Applicants may obtain additional information relating to technical and programmatic issues from Karen Hench, Division of Perinatal Systems and Women's Health, at (301) 443-9708.

2.3 Review Criteria and Process

To be considered for funding under this competition, applicants must be able to:

Develop methods that effectively motivate service providers to systematically and effectively screen and routinely assess for domestic violence during pregnancy using sound assessment methods that conform to professional recommendations such as those developed by ACOG or other national medical professional organizations and to coordinate and enable pregnant women experiencing domestic violence, either directly or through referrals, to safely and confidentially utilize appropriate medical, legal, counseling and law enforcement services as well as women's shelters. Assessment and intervention methods must be client-centered and appropriate to the age, linguistic and cultural characteristics of the populations served through this initiative in the applicant's community.

Develop and/or enhance a system of care that ensures linkages between health care providers and appropriate intervention programs including safe women's shelters for pregnant women experiencing domestic violence and that, to the extent possible that preserves the woman's safety and confidentiality, includes pregnant women who have experienced domestic violence in the project's planning and implementation.

[If the applicant is not the State/Territorial Title V or tribal health agency,]

Demonstrate a partnership between the applicant, the State/Territorial Title V or tribal health agency and the direct service facility(ies) providing care to pregnant women experiencing domestic violence that ensures consistency in screening, referral and intervention and contributes to capacity building within maternal and child health.

Failure to address all of the above program requirements may result in a disapproval of the application.

The review process for applications submitted under this competitive grant process will involve review by an Objective Review Committee (ORC) composed of multidisciplinary experts. The ORC will evaluate all eligible applications using weighted review factors and related criteria (See *Requirements for Project Narrative)*. The evaluation of each application will be based exclusively on the quality and responsiveness of the application to each required section of the project narrative (e.g. Factor I through V) and the programmatic-specific requirements. Each application will be rated on the basis of the following criteria:

Factor I (Weight 10%): Documentation of need

Factor II (Weight 40%): Soundness and adequacy of project plan

Factor III (Weight 20%): Soundness of evaluation plan

Factor IV (Weight 20%): Applicant = s capability and/or capacity

Factor V (Weight 10%): Appropriateness of budget

{ This Page Intentionally Left Blank }

CHAPTER 3 REQUIREMENTS FOR ABSTRACT AND PROJECT NARRATIVE

3.1 Project Abstract

3.1.1 Abstract or Summary of Project Narrative

Applicants should prepare a two to four page Project Abstract summarizing their proposed project according to the outline provided in Appendices A. This summary of project narrative (i.e., Project Abstract) will be published in the MCHB's annual publication entitled Abstract of Active Projects. This publication, which includes summaries of all MCHB-funded projects, is updated annually and is an important mechanism for dissemination of information about MCHB-funded projects. This publication is widely distributed to MCHB grantees, State Title V programs, academic institutions, and governmental agencies.

3.1.2 Text of Annotation

Prepare a three to five sentence description of the project that identifies the main purpose of the project and the gaps in the care system that it will address, the primary goals and objectives of the project, the activities to attain these goals, and the intended products and outcomes.

3.1.3 Key Words

Key words are the terms under which the project will be listed in the subject index of the MCHB Abstract of Active Projects. Identify the most significant terms that best describe the project, including the population served. Appendix B provides a sample of common keywords for MCHB-supported programs.

See Appendix A for further discussion of the proper format for the Project Abstract and Appendix C for a sample Project Abstract.

3.2 Project Narrative

The narrative must not exceed **40** pages. The content requirements for the Project Narrative portion of the application are divided into five sections and described below within each Factor, I through IV. Applicants must pay particular attention to structuring the narrative to respond clearly and fully to each review Factor and associated criteria.

The narrative must incorporate the headings (e.g., Factor I: Documentation of Need) and subheadings (e.g., Background of Need) as they appear below. The applicant may also choose to follow the same numerical label (e.g., 4.2.1) identified below to facilitate the review by the ORC. For each heading/subheading, the review factor and associated criteria will be stated, followed by instructions for the applicant that outline the minimal information required by the factor/criteria. [Note: The response to Factor V should be presented within the Budget and Budget Justification sections of your application and will not be presented sequentially in your Project Narrative after Factors I through IV.]

3.2.1 Factor I. (Weight 10%): Documentation of Need:

Background: Provide background information on domestic violence as it relates to the health and well-being of pregnant women within the State and the geographic area to be served by the applicant's proposal. Describe the current system for screening, routinely assessing, preventing, referring and directly intervening in cases of domestic violence including methodology and the types of health care providers (e.g., perinatal, emergency room) and key public/provider community agencies (e.g. women's shelters, counseling, legal and law enforcement services, advocacy centers) serving pregnant women experiencing or at risk for domestic violence. Describe the linkages, partnerships and/or referral mechanisms between the health care providers and key public/private community agencies. Describe any State Title V MCH program involvement in perinatal domestic violence screening, assessment, prevention and treatment activities.

Need: Thoroughly describe the need for the project in the proposed locale. Include baseline data on the prevalence and demographic characteristics of pregnant women experiencing domestic violence. As appropriate, include other quantitative and qualitative information from perinatal providers, women's shelters, legal and law enforcement or other providers of services to women experiencing domestic violence. Describe the gaps in the current system of care for pregnant women experiencing domestic violence. Identify gaps in the knowledge and capacity of health care providers and key public/private community agencies to adequately screen, routinely assess, effectively intervene and/or to coordinate their efforts within a comprehensive system.

3.2.2 Factor II. (Weight 40%): Soundness and Adequacy of Project Plan:

Proposed System: Describe your proposed system of care for pregnant women experiencing domestic violence that will be developed or enhanced, including: (1) the screening and intervention methodology that will be used, its efficiency and effectiveness, age and cultural appropriateness, sensitivity and rationale for use; (2) the linkages between health care providers and key public/private community programs and the efforts that will yield substantive, clearly defined partnerships between these providers and programs and that result in similar policies and procedures regarding screening and intervention for domestic violence, as appropriate; (3) the extent to which you will be able to involve women who have experienced domestic violence during pregnancy in the program planning and implementation while preserving their safety and confidentiality; and (4) measures to ensure the confidentiality and safety and to respect the rights of the pregnant woman being served by your project. The applicant should also indicate how the safety needs of the woman's children will also be ensured within the community.

Project Goals and Objectives: Identify the project's goals and the corresponding time-framed, measurable (e.g. quantified) objectives and activities to achieve these goals. Project goals and objectives must be appropriate in relation to the specific nature of State and local needs, the specified MCHB program requirements, and the special concerns listed in this guidance.

Methodology: In addition to the goals, objectives and activities listed above, describe the project plan (e.g. methodology) and its relation to the project=s goals and objectives and each of the program requirements. This section should include a description of:

how the project will ensure access to sufficient numbers of pregnant women experiencing domestic violence to be able to demonstrate effect;
specific strategies proposed to motivate providers to screen, routinely assess, intervene and/or refer for services for domestic violence;
points of contact within the system for pregnant women experiencing domestic violence, service protocols, and service delivery methods that maintain confidentiality, safety and respect a women's rights in decision-making. Briefly describe all services that will be available to the pregnant woman experience domestic violence during the screening, routine assessment, intervention and referral processes;

the adequacy and appropriateness of the proposed approaches that are client centered, age- and culturally-appropriate;
an indication of the degree to which the approaches are technically sound and appropriate to the project goals and objectives;
extent, content and method of training for service providers (e.g., prenatal, emergency room and other medical, legal, law enforcement, shelter staff) based on need; and
the plan for bringing together medical and key public/private community programs to jointly and regularly evaluate the system of care and each agency's role and to increase collaboration.

3.2.3 Factor III (Weight 20%): Soundness of Evaluation Plan:

Evaluation Plan: Describe the plan for evaluating the process and outcome of this project, particularly the degree of improvement from a baseline (pre-grant award) percentage of prenatal screening, routine assessments, referrals and interventions to the percentages projected to be reached at completion of the 3-year project and the extent to which the screening, referral and intervention activities are routinized and coordinated. Include baseline data on the number of pregnant women seen annually by the medical providers participating in your proposed system of care (e.g., providers who will be reporting annual data on the number of pregnant women screened for domestic violence and the number who were referred for intervention). For the purposes of this competition, specific outcomes do not need to focus on improvement of physical and mental health status, but instead should focus on the extent to which systems of care are developed or enhanced and institutionalized for women experiencing domestic violence. This section must include a discussion of currently available process and outcome measures and their respective baseline data as available, what additional measures you plan to include, and your anticipated changes in the process and outcome data over the three year project period.

Monitoring and Measurement: Describe the process to identify, measure and track key activities related to the achievement of project goals and objectives and that comply with MCHB=s evaluation protocol for discretionary grants and cooperative agreements. Describe the proposed project's safe and confidential system for tracking that pregnant women experiencing domestic violence are actually accessing needed services.

3.2.4 Factor IV (Weight 20%): Applicants Capability and/or Capacity Within the Field of Domestic Violence Against Pregnant Women:

Experience and Capability: Describe your agency's capability to successfully carry out the project (e.g. other projects for women experiencing domestic violence in which your agency or its staff have been actively involved). If the applicant is other than the State/Territorial Title V or tribal health agency, the applicant must provide convincing evidence that a strong relationship exists or is being created between the Title V or tribal health agency and direct service facility(ies) providing prenatal care to women that ensures consistency in screening, routine assessment and intervention strategies and contributes to capacity building within maternal and child health.

Training Capability: Provide significant evidence of the ability of your agency and its staff and/or contractors to provide appropriate training based on need throughout the system of care and, in particular, to motivate providers to offer age and culturally appropriate and sensitive screening, routine assessment, and safe and confidential intervention and referral in the area of domestic violence.

Staff Capability: Provide evidence that a sufficient number of qualified project personnel and resources are proposed. In the Appendices, include a curricula vitae for each staff member included in the budget. The curriculum vitae should document education, including training in the area of domestic violence against (pregnant) women, skills, and experience that are relevant and necessary for the proposed project. Describe by objective and activity, the allocation of project staff and consultants. A suggested format is presented in Appendix J and should be included in the appendices of your application.

Contribution to MCH: Identify the extent to which the project will contribute to the advancement of perinatal and women's health within the maternal and child health system.

3.2.5 Factor V (Weight 10%): Appropriateness of Budget:

[Note: The response to Factor V should be presented within the Budget and Budget Justification sections of your application and will not be presented sequentially in your Project Narrative after Factors I through IV.]

Budget Summary: The ORC will rate the reasonableness of the budget and its consistency with proposed activities for **each budget year** requested for the project period of three years.

Itemized Justification: The ORC will rate the adequacy of the line item budget (SF 424A form) and the coinciding justification to support **each of the three budget years.** A justification for each of the requested items relative to the project plan including person hours for staff, travel items, equipment, contractual services, supplies, and other categories must be provided. Travel cost justification must include who, where, length of time, purpose and associated costs for each trip. Applicants must budget one trip a year for up to two persons for three days to Washington, D.C. Applications submitted without a budget and justification for each budget year requested may not be favorably considered for funding.

Adherence to Budget Requirements: The ORC will rate the extent to which the applicant adheres to budget requirements (e.g., travel to Washington, D.C.; no supplanting of existing funding, no direct costs for developing new screening tools).

Contractual Services: If contractual services are proposed, the ORC will rate the adequacy of the justification for the contract, its scope, and costs.

APPENDIX A - Abstract: Format And Guidelines

Format:

The abstract, excluding the Text of Annotation, and Key Word List, must NOT EXCEED A FOUR-PAGE description of your project. Format guidelines are as follows:

Margins should be 1 inch at the top, the bottom, and both sides.

- Use a standard (non-proportional) 12 pitch font or typefaces, such as Courier or New Times Roman. Please use plain paper (not letterhead stationary or paper with borders or lines) and avoid "formatting" (do not underline, use bold type or italics, or justify margins).

- Capitalize only the first letter of principle words when filling in the lines at the top of the form. Be sure to include the area code with the telephone number, and the full mailing address (including street and/or P.O. Box) with the zip code.

- Type section headings in all capital letters followed by a colon and two spaces. Begin the narrative immediately after the two spaces. Do not indent paragraphs, but do double-space between them. Sections should be single-spaced.

- In addition to the original copy of the Abstract in the application, send a second copy and a disk copy in a separate envelope with the Grant (See *Chapter 2: Application and Review Process, 2.2.5 Copies Required*). Please indicate the type of software and operating system used (e.g., Word Perfect (IBM or Mac), Word (IBM or Mac), MacWrite) on the envelope and/or disk label.

- Include the following components in your abstract:

Project Identifier Information

Project Title:	List the title as it will appear
Project Number:	Leave blank; Number will be assigned when grant is awarded
Project Director:	The name and degree(s) of the project director as listed on the grant
Contact Person:	The person to be contacted by those seeking information about your project
Applicant Agency:	The organization which is applying for the grant

Address:	The complete mailing address of applicant agency
Phone Number:	Include area code, phone number, and extension if applicable
Fax Number:	Include fax number
E-mail Address:	Include electronic mail address
Internet Address:	Include World Wide Website address for applicant agency
Project Period:	Include the entire proposed funding period, not just the one-year budget period

Abstract or Summary of Project Narrative: <u>Use the following format to emphasize</u> the project's uniqueness, creativity and expertise.

PROBLEM:

Briefly describe the project area, statement of need, current system for screening, routinely assessing, referring and intervening in cases of domestic violence against pregnant women that is utilized by medical providers and key public/private community organizations and the critical gaps in this system.

GOALS AND OBJECTIVES:

Identify the major goals and objectives for the 3-year project period that clearly relate to the program requirements and address the special concerns listed in the program guidance. Objectives should be time-framed and measurable.

METHODOLOGY:

Describe the project plan and highlight novel activities which will be used to attain the goals and objectives.

COORDINATION:

Describe the coordinated system of care that is planned and linkages that will be implemented or enhanced between appropriate medical providers and key public/private community organizations in area(s) to be served by the project.

EVALUATION:

Briefly describe the evaluation methods and process/outcome measures which will be used to assess the effectiveness and efficiency of the project in attaining its objectives and in improving the system of care for pregnant women experiencing domestic violence. Methods for data collection and analysis should be clearly defined and incorporate commonly used analytical methods.

Text of Annotation

Prepare a three to five sentence description of the project that identifies the main purpose of the project and the gaps in the care system that it will address, the primary goals and objectives of the project, the activities to attain these goals, and the intended products and outcomes.

Key Words

Key words are the terms under which the project will be listed in the subject index of the MCHB Abstract of Active Projects. Identify the most significant terms that best describe the project, including the population served. Appendix B provides a sample of common keywords for MCHB-supported programs.

APPENDIX B - List of Keywords

A list of keywords used to describe MCHB-funded projects follows. Please choose from this list when selecting terms to classify your project. If no term on this list adequately describes a concept which you would like to convey, please select a term which you think is appropriate and include it in your list of keywords.

Please note that this list is constantly under development; new terms are being added and some terms are being deleted. Also, this list is currently being revised so that it will match more closely the approved list of keywords in the MCH Thesaurus. In the meantime, however, this list can be used to help select keywords to describe MCHB-funded projects.

A

Abuse
Access to Health Care
Adolescent Health Programs
Adolescent Nutrition
Adolescents
Advocacy
African Americans
AIDS
Alaska Natives
Alcohol
American Academy of Family Physicians
American College of Nurse Midwives
American College of Obstetricians and Gynecologists
American Medical Association
American Public Health Association
Asians

B

Battered Women
Behavior Disorders
Body Composition

C

Caregivers
Case Management
Child Abuse
Child Care Centers
Child Care Workers
Chronic Illnesses and Disabilities
Clinics
Cocaine
Co-located Services
Communication Disorders
Community Based Health Education
Community Based Health Services
Community Based Preventive Health
Community Development
Community Health Centers
Community Integrated Service System
Community Partnerships
Compliance
Comprehensive Primary Care
Continuity of Care
Cost Effectiveness
Consumer Participation
Counseling
County Health Agencies
Cultural Diversity
Cultural Sensitivity

D

Decision Making Skills
Depression
Diagnosis
Dispute Resolution
Dissemination
Divorce
Domestic Violence

E

Emotional Health
Employers
Employees

F

Families
Family Centered Health Care
Family Centered Health Education
Family Characteristics
Family Environment
Family Medicine
Family Planning
Family Relations
Family Support Programs

APPENDIX C - Sample Abstract

Project Title:	Alcohol Screening Assessment in Pregnancy (ASAP) Project
Project Number:	
Project Director:	Calvin Klein, Ed.D and Norma Komali, Ph.D
Contact Person:	Donna Karan
Applicant Agency:	Northeast Department of Public Health
Address:	250 Truman Street
	Northeast, Somewhere 00000
Phone Number:	000/123-4567
Fax Number:	000/987-6543
E-mail Address:	yourname@state.us
Internet Address:	www.state.us
Project Period:	7/1/99-6/30/02

PROBLEM: In 1995, according to the Northeast Behavioral Risk Factor Surveillance System (BRFSS), one in six pregnant women contacted by phone, responded that they had had an alcoholic beverage during the past month and over 3% of pregnant women reported drinking frequently. The 1995 BRFSS also indicated that 67.2% of women of childbearing age (900,000) reported drinking any alcohol, compared to 51% nationally. This is the second highest rate in the country. Also, 17.4% of these same Northeast women reported drinking frequently, compared to 13% nationally. Therefore, approximately 230,000 women of childbearing age in Northeast drink alcohol frequently. In contrast, according to the Pregnancy Nutrition Surveillance Survey data (PNSS), collected by the Northeast Department of Public Health's Title V funded perinatal programs in 1996, only 10.5% of pregnant women reported drinking any alcohol during the 3 months prior to pregnancy, 2.7% from the date of conception to the first prenatal visit, 1.5% during the last trimester, and 2.3% between the birth and the first postpartum visit. Northeast birth certificate data, using self report information from the mother in the birth hospital during an interview with hospital staff, recounts that, of the close to 80,000 births in 1996, 2.7% of birth mothers reported drinking alcohol during pregnancy.

The fact that the BRFSS (over the telephone) data reports that the Northeast has such high numbers of child-bearing women drinking alcohol and yet the PNSS data reports (face-to-face interviews) so few pregnant women drinking raises concern with the accuracy of the PNSS reports. It is highly unlikely that in a state in which 17.4% of women of child bearing age report drinking frequently, only 10.5% of pregnant women report drinking at all during three months prior to pregnancy. Prenatal care providers recognize that the information they receive from their clients concerning substance use is inaccurate. These data illustrate further the need for a screening and brief intervention model that does not depend on face-to-face interviewing and that is supported by intensive training and ongoing consultation and assistance to prenatal care providers.

GOALS AND OBJECTIVES: The goals and objectives of the ASAP Project are: 1) To motivate prenatal care providers to routinely screen for alcohol and other drugs. The ASAP Project proposes to first engage 25 prenatal care providers who have personally expressed or who are employed in an

agency which has expressed an interest in the goals of this project to provide information and training concerning the impact of alcohol and drug use in pregnancy within the first 9 months of the first budget year; 2) To establish protocols for the determination and utilization of appropriate interventions. By the end of the first budget year, the ASAP Project proposes to train 2 clinical staff at each site in NIAAA's brief intervention model and to work with the staff to incorporate this model into their existing framework of patient counseling and education; 3) To develop a support system of care to provide ongoing screening and appropriate brief intervention. The ASAP Project will provide ongoing support for 25 providers for problem solving and resource identification that will be easily accessible and available during prenatal care office hours. A 6 month public education/media campaign will be implemented to "normalize" conversations about use of alcohol and other drugs during pregnancy; 4) To strengthen the cross-system linkages for resources. The ASAP Project will coordinate 6 seminars (2 per year) for interaction between providers of prenatal services and substance abuse services; 5) To create practice-based knowledge products for routine screening, intervention and referral. Within the first 6 months of the first budget year, the ASAP Project will develop a training curriculum for prenatal providers on the use of the screening tool, brief intervention and clinical decision tree/protocols to foster the replication of the ASAP model.

METHODOLOGY: The ASAP Project proposes to motivate prenatal care providers to use the 4 P's screening tool embedded into existing paperwork that pregnant women complete themselves while in prenatal care waiting areas. The questionnaire will be reviewed by medical intake staff who will engage in a brief intervention with the pregnant woman based on her responses to the 4 P's. A clinical decision tree/protocol will be developed with input from the providers that will facilitate clinician decision-making during the brief intervention. Clinicians will have direct access to educational materials about alcohol and other drug use during pregnancy as well as referral resources, should the client want to participate in a substance abuse assessment, or should a referral to treatment be appropriate. Materials will be available in English, Spanish and Khmer.

Prenatal care staff will be supported through training that focuses on effects of maternal alcohol and other drug use, documented success of brief interventions within the medical office setting on alcohol and other drug use, and availability and access to substance abuse assessment and treatment resources. Training will be provided by two physicians with expertise in training and utilizing the project's screening and brief intervention protocols and by ASAP Project staff. Ongoing support, referral and consultation will be provided to staff as they implement the screening, counseling and referring protocols. Staff will have access to immediate support over the telephone or in person.

The ASAP Project will initiate a statewide public education/media campaign that will include expansion of the distribution of an existing outreach tool, developed through consumer focus groups, advertising the statewide substance abuse prevention and treatment BSAS-funded Helpline. In addition, a distribution of educational materials through existing maternal and child health programs as well as Medicaid will be part of the project activities.

The prenatal care providers for the first year of the ASAP Project include four community health centers and one private practice. These sites are located in East, Central and North Regions. The

population served by these sites is very diverse ethnically, racially, economically and by age. During the second year, the ASAP Project will work with University Vanguard, one of the largest and oldest health maintenance organizations in Northeast. The University Vanguard serves the metro-Northeast area. The third year will include additional community health centers and health maintenance organizations, which have already expressed interest in participating.

COORDINATION: The ASAP Project is a result of many years of collaborative efforts between IHR and NEDPH Bureau of Family and Community Health and Bureau of Substance Abuse Services. IHR's primary goal is to promote collaboration through linkages and affiliations, particularly between agencies and service delivery systems which may not traditionally be expected to work together. Each goal of the project involves an integration of the substance abuse and MCH systems; coordination will happen at several levels. At each demonstration site, a point person will be identified to coordinate all ASAP Project activities, including the evaluation by HAR. The PCIF and Project Coordinator will tailor the screening instrument and intervention protocol with provider and office staff to assure the smooth integration of this model. Coordination of trainers, training content and meeting logistics will be done by IHR. IHR will also work with BSAS and targeted substance abuse programs to promote interaction with perinatal providers and to arrange cross training. Within the Department of Public Health, staff from the BFCH and BSAS also have discrete roles within the project. The Project Coordinator meets frequently with the BSAS Coordinator of Women's Services.

EVALUATION: Evaluation will be conducted by Health and Addiction Research, Inc., a research evaluation firm with a long-standing relationship with both NEDPH and IHR. Evaluation will focus on seven primary questions: 1) Can a brief screening tool such as the 4 P's be successfully integrated into the providers' routine practice? 2) Will clinicians deliver an immediate, brief intervention, when appropriate to women during routine prenatal visits? 3) Can an effective clinical protocol and decision tree be developed for clinicians to use in prenatal care settings? 4) Will technical assistance and ongoing consultation delivered by the project team facilitate this effort? 5) Does a public media education and campaign improve detection of substance abuse problems among pregnant women? 6) Will project-developed information and products reach target populations? 7) Will this project improve reporting for the state's data collection efforts? A variety of materials and methods will be utilized including Meeting Evaluation Forms, Training Evaluation Forms, and a Start-up Implementation Questionnaire. Other data collection efforts include: a Biannual Implementation Survey; Chart Reviews; Case Manager logs; Public Education Campaign Evaluation, including referrals to the Helpline; and information extracted from Perinatal Primary Care Programs' case records statewide.

TEXT OF ANNOTATION: The ASAP Project will motivate prenatal care providers to routinely screen for alcohol and other drug use during pregnancy. Strategies include: training, ongoing consultation, a clinical decision tree/protocol, a self-administered screening tool, a brief intervention counseling model, a public education media campaign, and knowledge product development.

KEY WORDS: Alcohol; Case Management; Cocaine; Community Based Health Services; Community Health Centers; Community Integrated Service System; Comprehensive Primary Care; Continuity of Care; Dissemination; Fetal Alcohol Effects; Fetal Alcohol Syndrome; Health Education;

Health Maintenance Organizations; Health Professionals; Interagency Cooperation; Low Birthweight; Marijuana; Nurse Midwives; Nurses; Obstetricians; Perinatal Health; Pregnant Women; Prenatal Care; Prenatal Screening; Preterm Birth; Preventive Health Care; Provider Participation; Public Health Education; Referrals;; Screening; Standards of Care; State Programs; State Systems Development Initiatives; Substance Abuse; Substance Abuse Prevention; Substance Abuse Treatment; Substance Abusing Mothers; Substance Abusing Pregnant Women; Substance Exposed Infants; Title V Programs; WIC

APPENDIX D - Guidelines for Budget and Budget Justification

General:

In addition to the enclosed "DHHS - PHS Grant Application, Form PHS 5161-1" (Instructions) and the general information presented in the section 4.2.5 entitled *Factor V: Appropriateness of Budget* of this guidance, the following specific instructions are provided to assist applicants in preparing their budget proposal and budget justifications. To streamline the grants process, HRSA/MCHB is requesting multi-year budget submissions. Funding for each year of the three year project period is based upon the availability of funds and satisfactory programmatic progress. The submitted budget for the second and subsequent years of the project period can be estimations.

The budget justification requires the applicant to show how specific line items support the project. All costs in each submitted budget should be reasonable, necessary and consistent with the project's proposed models, objectives and activities. Because of its anticipated length, the narrative Budget Justification will not be counted toward the page limit of the application, but should be placed in front of the abstract and have **sequentially numbered** pages.

Project Period and Budget Period Specifications:

Multi-year budgets are required from all applicants; the program-specific details are provided below.

"Project Period: The total time for which support of a discretionary project has been programmatically approved. A project period may consist of one or more budget periods. The total project period comprises the original project period and any extensions."

"Budget Period: The interval of time (usually 12 months) into which the project period is divided for budgetary and funding purposes."

(Ref.: PHS Grants Policy Statement, April 1, 1994, pp. 2-3 and 2-1)

Funding Utilization and Budgeting Requirements:

Funds may only be used to supplement and not supplant other Federal and non-Federal funds that would otherwise be made available for the project.

Shared Staffing: Applicants proposing to utilize the same director or contractual staff across multiple grants (e.g.CISS, HSI, State Title V block grant) should assure that the

combined funding for each position does not exceed 100% FTE. If such an irregularity is found, funding will be reduced accordingly.

Object Class Categories

(Line 6): The following PHS Instructions for Form 424A, "Section B - Budget Categories, (line) 6. Object Class Categories" are defined as follows.

Personnel

The salaries and wages of only those project staff directly employed by the grantee agency should be reflected in this object class category. The total costs (including local travel) for those project staff hired by the grantee agency as consultants or through individual or agency contracts should be itemized under the appropriate object class category, "Consultant Costs" (see Item 3 below) or "Contractual" (see Item 10 below).

For all grantee agency staff involved in the project, list each position with annual salary level and percentage of full time equivalency (FTE) on the SF 424A Supplement - Key Personnel Form found in Appendix E. In listing the positions on this form, provide the name and degrees (as appropriate) of the incumbent if the position is filled (e.g., John Doe, MSW), and vacant, (e.g., "vacant - PHN") if the position is new or not filled as of the date of application submission. If the project has multiple employees in both the same position and same % FTE (e.g., full-time outreach workers), enter the number of positions filled on one line and the number of positions vacant on the subsequent line (e.g., line 1: 10 outreach workers [7.5 FTE] filled...., line 2: 5 outreach workers [3.75 FTE] vacant...)

The Budget Justification narrative should include a succinct description of the specific role and activities of each position funded by the proposed project. Position descriptions, along with two page curricula vitae for all key staff positions (i.e. Project Directors, Project Coordinators, etc.) for which grant support is requested, must be included unless these have been submitted previously.

Fringe Benefits

Costs should be calculated using the grantee agency's formally established policy. The Budget Justification narrative should indicate the numerical rate used by the grantee agency.

Travel

This category should be divided into local and out of area/long distance travel costs for grantee agency staff only; travel costs for consultants or contractors should be included in those corresponding lines (i.e., 'consultant', 'contractual'). For each proposed long distance trip, the budget justification must provide the trip's purpose and destination, and the estimated unit cost for: a) transportation, b) rate of per diem (meals and lodging), and c) the number of persons and duration of travel.

Each project should include budget estimates for up to two persons to travel round-trip to the Washington, D.C. area for up to three days duration per year to attend a grantee or other related meeting/conference.

Equipment:

Any durable good having a unit cost in excess of $5,000 is considered equipment. In the budget justification, describe the equipment by individual item, unit cost, quantity, and physical location of proposed equipment (e.g., grantee, subcontractor).

Supplies

A guideline of $500 per full-time project employee per year can be used to estimate the cost for office supplies. For other supplies, describe types and costs (e.g., public information materials, computer items under $5,000 unit cost, and supplies).

Contractual

A budget for each contractor or sub-contractor, prepared and justified using these same instructions (including indirect costs), should be included in line 6-f, 'Contractual'. It must be emphasized that PHS grant regulations permit grantees to use funds for contracts and subcontracts but not for subgrants.

Consultants should also be included in this line item, but they should be listed separately. Detail the hourly rate, and estimated total number of hours needed; the justification should include the type of consultant services needed, and role the consultant(s) will play in the project activities.

Construction (Alterations and Renovations)

Construction will not be an allowable cost; however, for alterations and renovations refer to PHS Grants Policy Statement, (April 1, 1994) pp. 7-2, -3, and -4 for guidelines.

Other

Describe each item with itemized associated costs.

Total Direct Charges

Total all line item costs of the categories above.

Indirect Charges

For Indirect Costs, see Instructions in PHS 5161-1 (dated seven/92), p.21, or, PHS 5161-1, (dated 5/96), p.23. Please note that if indirect costs are requested, the grantee must submit a copy of the latest negotiated rate agreement (on same pages). The indirect costs rate refers to the "Other Sponsored Program/Activities" rate and not the research rate.

APPENDIX E - Supplement to Section F of Form 424a

KEY PERSONNEL

NAME AND POSITION TITLE	ANNUAL SALARY	# of MONTHS BUDGETED	% TIME	TOTAL $ AMOUNT REQUESTED
	(1)	(2)	(3)	(4)
	$		%	$
FRINGE BENEFIT				
(Rate____)			TOTAL	$

{ This Page Intentionally Left Blank }

APPENDIX F - Instructions for Completing the Application

In evaluating the applications, reviewers will use only the information presented in the application to assess the applicant's response to the Review Factors and Criteria. It is essential that the application and responses to the Review Factors and Criteria are clear, complete and adequately supported by necessary data, as appropriate.

Format and Style

This section provides detailed instructions for formatting and organizing the grant application. A clearly written and easy-to-read grant proposal should be the goal of every applicant, since the outcome of the review process depends on information provided in the application narrative. Therefore, MCHB urges all applicants to review their applications for the following:

- Correct grammar, spelling, punctuation, and word usage.
- Consistency in style. Refer to a good style manual, such as The Elements of Style by Professors William Strunk, Jr. and E. B. White, *Words into Type*, *The Chicago Manual of Style*, or GPO's *A Manual of Style*.
- Consistency of references (e.g., in this guidance document the Maternal and Child Health Bureau is called the Maternal and Child Health Bureau or MCHB.)

How to Format the Application

MCHB prefers that the format and style of each application substantially reflect the format and style used in this guidance. To promote readability and consistency in organization, MCHB has established specific conventions for the format of the project narrative, its project abstract, and appendices. Conventions for each are discussed below. Wherever conventions for the individual parts of the grant proposal differ, the parts are discussed separately. Otherwise, the specific convention applies to all parts of the grant proposal.

Table of Contents

A Table of Contents is required. Use the Table of Contents of this Guidance as a formatting and style guide.

Page Headings

The name of the project should appear in the top left corner of each page of the project abstract, project narrative, and appendices as a header.

Margins

The initial left and all right margins should be 1 inch. Top, bottom, and right margins should be 1 inch each.

Headings and Indentations

The section headings used in this document are also to be used in your application. Note also the progressive indentation of each subdivision and sub-subdivision. The initial subheadings only are underlined. This visually distinguishes them from their subordinate subdivision. The latter are indented more than their superiors. This is carried out through the text of the document. This format will allow all users to locate desired text efficiently. In addition, it should assist reviewers in quickly locating text under particular subheadings to facilitate comparisons among competing applications.

Headings

Section headings in all parts of the grant application should be typed flush left in all caps, bold type. Subordinate ranks of subheadings are indented in accordance with their respective ranks.

(1) Project Abstract

Center the words "project abstract" in all caps, bold type, on the first line of the document (if using word-processing software) or 1-1/2 inches from the top of the paper (if typing).

(2) Project Narrative

Center the words "project narrative" and follow the instructions for the project abstract described above.

(3) Appendices

Identify appendices by labeling and titling each appendix. All attachments should be compatible with the suggested format.

Page Limit and Spacing

Note: If applications exceed the limits specified below, they are subject to being returned without review.

(1) Project Abstract

The project abstract may not exceed four pages. Only single-spaced, one-sided pages are acceptable. (See Appendix A and C.)

(2) Project Narrative

The project narrative may not exceed 40 pages. The page limit includes any referenced charts or figures but does not include the project abstract, the budget justification, tables, nor appendices. Only single-spaced (with double-spacing between paragraphs), one-sided pages are acceptable. Consecutive, Arabic numerals (beginning with 1) should appear centered at the bottom of each page. They should paginate all charts or figures appearing within the body of the text consecutively with the text.

(3) Appendices

Appendices should include all supporting documentation, such as: (1) organizational chart, position descriptions and curricula vitae; (2) Project Personnel Allocation Table (See Appendix J); and (3) memoranda or letters of agreement and support. This includes the Title V designation letter from non-Title V applicants. Position descriptions and curricula vitae must not exceed two pages each. Centered at the bottom of each page, label each page of the appendix with the Consecutive Uppercase Letter reflecting the appendix section followed by the page number using Consecutive, Arabic numerals (beginning with 1), e.g. A-1, A-2...B-1, etc.

Typeface

Use any easily readable serif typeface, such as Times New Roman, Courier, or New Century Schoolbook.

Type Size

Size of type must be 12-point. Type density must be no more than 15 characters per inch. No more than six lines of type per vertical inch are allowable. Figures, charts, legends, footnotes, etc., may be smaller or more dense, but must be legible.

Page Numbering

(1) Budget

Consecutive, Arabic numerals (beginning with 1) should appear centered at the bottom of each page

(2) Table of Contents

Consecutive, lowercase Roman numerals should appear centered at the bottom of the appropriate page.

How to Organize the Application

You should assemble the application in the order shown below:

- Table of contents for entire application with page numbers
- SF-424 Application for Federal Assistance
- Checklist included with PHS 5161-1 (Application Kit, pages 25-26 of the version revised 5/96; pages 23-24 of the version revised 7/92.)
- SF 424A Budget Information--Non-Construction Programs
- Budget justification (Appendix D)
- Personnel form (Appendix E)
- Federal assurances (SF 424B)
- Project abstract (Appendix A)
- Project narrative
- Appendices (includes Project Personnel Allocation Table and, if applicable, a Title V MCH designation letter)

Copies Required

Applicants are required to submit one ink-signed original and two copies of the completed application. In addition to the original copy of the Abstract in the application, send a second paper copy and a disk copy of the Abstract in a separate envelope that is included with the grant application. Please indicate the type of software and operating system used (e.g., Word Perfect for Windows or MacIntosh, Word for Windows or MacIntosh) on the envelope and/or disk label.

Requirements

To be considered for funding under this competition, applicants must meet **all** of the requirements listed below. If an applicant fails to meet one of these requirements, the application may not be accepted for review and may be returned to the applicant.

- Complete required official application and standard forms and provide budget justification.

- Provide a complete application which addresses all review criteria in a substantive manner in the required format.

Each of these requirements is discussed in detail below.

Overview of Application Form PHS 5161-1 and Related Program Concerns

An official application is composed of seven sections which are described more fully in the formal grant application form entitled PHS Grant Application Form PHS 5161-1 (revised 5/96 or 7/92; use of either revision is acceptable).

- The first section contains information about PHS policies and procedures.

- The second section, SF-424, is the face page and requests basic information about the applicant and project.

- The third section, SF-424A (non-construction) pertains to budget information (see budget narrative, page 23 in 5/96 document or page 21 in 7/92 document).

- The fourth section, SF-424B, concerns assurances and must be signed by an authorized representative of the applicant organization.

- The fifth section concerns Certifications (page 17 in both versions).

- The sixth section concerns the program narrative (page 21 in 5/96 version or page 19 in 7/92 document).

- The last section consists of a checklist which must be included with all applications (pages 25-26 in 5/96 document or pages 23-24 in 7/92 document).

Standard Forms 424C and 424D are not necessary for this application and should be ignored. **Selected portions of the instructions are amplified and highlighted here:**

- The Catalog of Federal Domestic Assistance Number is 93.926G.

- F-424, Item 10, for Program Title, enter the title of the competition.

- SF-424, Item 13, enter the dates for the complete project period (May 1, 2000 - April 30, 2003).

- The following instructions should be used in completing SF-424A:

For each part of SF-424A, Section B budget categories, applicants must submit on supplemental sheet(s) an itemized justification for each individual budget category line (6a-j). Applicants typically identify the specific needs, but often fail to write a justification of those needs. These detailed budget justifications require the applicant to show specific references to the project plan related to how the requested dollar amount was developed. Applicants are not required to submit copies of contracts; however, personnel, scopes of work, budgets, and budget justifications of contracts are required by the Grants Management Branch, MCHB. Appendix D provides additional guidance on budget justification.

The Key Personnel Form

Appendix E may be used as a supplement to the budget narrative. Key personnel can be identified by name (if known), total percent of time and salary required under the grant, and if applicable, amounts provided by in-kind or other sources of funds (including other federal funds) to support the position. The budget justification for personnel must address time commitment and skills required by the project plans. Similar detailed and itemized justifications must be provided for requested travel items, equipment, contractual services, supplies and other categories. Please note that if indirect costs are requested, the applicant must submit a copy of its latest negotiated rate agreement (page 23 of PHS SF 5161-1revised 5/96 or page 21 of 7/92

revision). The indirect cost rate refers to the "Other Sponsored Programs/Activities" rate and not the research rate.

Project Abstract

A project abstract must be submitted. See *Requirements for Project Narrative, 4.1 Project Abstract* and Appendices A and C.

Complete, Responsive Application

Applicants must submit applications, including line item budgets, that have been developed in accordance with this application guidance. The application and its contents should follow the order of the application guidance. Each review Factor and related criteria should be fully addressed and provide the information requested in a substantive manner.

Preparing the Appendices

Appendices should be brief and supplemental in nature. Refer to the style and format section of this Section for specific conventions to be followed in formatting appendices. A list of appropriate appendices follows, along with the order in which they should be submitted:

Appendix Content

Documentation and description of relationships between the proposed program and affiliated departments, institutions, agencies, or individual providers, and the responsibilities of each. Examples of documentation include: letters of support, understanding, or commitment and memoranda of agreement that specifically identifies the activities and/or products that will occur as a result of the partnership and this initiative and the Project Personnel Allocation Table (See Appendix J). The Appendices should also include the Title V MCH designation letter from non-Title V applicants.

Refer to the Checklist for a complete listing of all components to be included in the application:

Checklist

- Position descriptions for all professional and technical positions for which grant support is requested and any positions of significance to the program that will be supported by other sources. At a minimum, describe the following:

-- Administrative direction and to whom it is provided;

-- Functional relationships (e.g., to whom does the individual report and how does the position fit within its organizational area;

-- Duties and scope of responsibilities;

-- Minimum qualifications (e.g., the minimum requirements of education, training, and experience needed to do the job);

-- Position descriptions reflect the functional requirements of each position, not the particular capabilities or qualifications of given individuals.

-- Each position description should be separate and must not exceed two pages in length.

- Curricula Vitae -- Include vitae for key staff. Key staff includes Project Director/Coordinator and other relevant staff. Each curriculum vitae must not exceed two pages and should be placed behind the appropriate position description.

APPENDIX G - Checklist For Competitive Application FY 2000

SUBMIT 1 ORIGINAL, INK-SIGNED APPLICATION AND 2 SIGNED COPIES, ALL NUMBERED AND UNBOUND (FOR EASE OF COPYING). INCLUDE THE FOLLOWING:

1. ____ Letter Of Transmittal
2. ____ Table Of Contents For Entire Application With Page Numbers

Budget Information

3. ____ SF 424 Application For Federal Assistance
4. ____ Checklist Included With PHS 5161-1, (Page 23) *Application Kit*. Provide The Name, Address, And Telephone Number For Both The Individual Responsible For Day-To-Day Program Administration And The Finance Officer.
5. ____ SF 424A Budget Information--Non-Construction Programs
6. ____ Budget Justification

   (Includes The Narrative, Supplemental Sheets and Key Personnel Form,-

   See Appendices D and E)

Federal Assurances

7. ____ Intergovernmental Review Under E.O. 12372, If Required By State
8. ____ SF 424B Assurances--Non-Construction Programs
9. ____ Department Certification (45 CFR Part 76)
10. ____ Certification Regarding Drug-Free Workplace Requirements
11. ____ Certification Regarding Debarment and Suspension
12. ____ Lobbying Certification
13. ____ Public Health System Impact Statement

Description Of Program

14. ____ Project Abstract, Maximum Of Four Pages (See Appendices A and C)
15. ____ Project Narrative, Maximum Of 40 Pages
16. ____ Project Appendices

{ This Page Intentionally Left Blank }

APPENDIX H - Reference List

American College of Obstetricians and Gynecologists. Domestic Violence. Technical Bulletin Number 209. Washington DC: ACOG, 1995

American Medical Association, Council on Scientific Affairs. Violence against women. Relevance for medical practitioner. JAMA 1992;267:3184-3189

Gazmararian, J., Lazorick, S., Spitz, A., Ballard, T, Saltzman, L., & Marks, J. Prevalence of violence against pregnant women: A review of the literature. JAMA 1996;275:1915-1920

Petersen, R., Gazmararian, J., Spitz, A., & Rowley, D. Violence and adverse pregnancy outcomes: A review of the literature and directions for future research. American Journal of Prevention Medicine. 1997; 13:5 366-372

Petersen, R., Saltzman, L., Goodwin, M., & Spitz, A. Key scientific issues for research on violence occurring around the time of pregnancy. CDC. Atlanta, GA, 1998

The Commonwealth Fund. Addressing domestic violence and its consequences. Policy report of the commonwealth fund commission on women's health. Columbia University, New York, NY, February 1998.

Wiist, WH, McFarlane J. The Effectiveness of an Abuse Assessment Protocol in Public health Prenatal Clinics. *American Journal of Public Health.* 1999; 89 1217-1221.

{ This Page Intentionally Left Blank }

APPENDIX I - State Title V Directors

Maternal and Child Health (MCH)

ALABAMA
Thomas M. Miller, M.D., M.P.H., FACOG
Director
Bureau of Family Health Services
Alabama Department of Public Health
201 Monroe Street, Suite 1360
Montgomery, AL 36104
(334) 206-2940
(334) 206-2950 FAX

ALASKA
Pam Muth, MPH
Section Chief
Alaska Department of Health and
Social Services
1231 Gambell Street
Anchorage, AK 99501-4627
(907) 269-3400
(907) 269-3414 FAX

AMERICAN SAMOA
Joseph Tufa, DSM, MPH
Director, Div. Of Preventive & Environmental Health
American Samoa Government
LBJ Tropical Medical Center
Pago Pago, American Samoa 96799
9-011-684-633-4606
9-011-684-633-5379 FAX

ARIZONA
Marianna Bridge, RNC, MS
Chief, Office of Women's & Children's Health
Arizona Department of Health Services
411 N. 24th Street, Birch Hall
Phoenix, AZ 85008
(602) 220-6550
(602) 220-6551FAX

ARKANSAS
Richard Nugent, MD, MPH
Medical Dir., Maternal and Child
Health Section
Arkansas Department of Health
4815 West Markham, Slot No.41
Little Rock, AR 72205-3867
(501) 661-2199
(501) 661-2055 FAX

CALIFORNIA
Rugmini Shah, M.D.
Branch Chief
Maternal and Child Health Branch
California State Department of Health
Services
714 P Street, Room 750
Sacramento, CA 95814
(916) 657-1347
(916) 657-3069 FAX

COLORADO
Merril Stern, MA
Director, Family and Community Health Services
Colorado Department of Public Health and
Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530
(303) 692-2302
(303) 753-9249 FAX

CONNECTICUT
Jadwiga Goclowski, Ph.D., R.N.
Director
Family Health Services Division
Bureau of Community Health Services
Connecticut Department of Public
Health Services
P.O. Box 340308
410 Capitol Avenue - MS #11FHS
Hartford, CT 06134-0308
(860) 509-8066
(860) 509-7720 FAX

DELAWARE
Joan Powell, MPA
Director, Family Health Services
DE Division of Public Health
P.O. Box 637
Dover, DE 19903
(302) 739-4785
(302) 739-6653 FAX

DISTRICT OF COLUMBIA
Michelle Davis, MSPH
Interim Chief
DC Maternal and Child Health
Commission of Public Health
800 9th Street, S.W., Third Floor
Washington, DC 20024-2480
(202) 645-5624
(202) 645-0453 FAX

FLORIDA
Annette Phelps, MSN, RN
Exec. Community Health Nursing Dir.
Florida Department of Health/
Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
(850) 488-2834
(850) 488-2341 FAX

GEORGIA
Rosalyn Bacon, MPH
Director, Family Health Branch
Division of Public Health
Georgia Dept. of Human Resources
2 Peachtree Street, N.W.
Suite 8-113
Atlanta, GA 30303-3142
(404) 657-2850
(404) 657- 7307 FAX

GUAM
Faye Carbalito
MCH/CSHN Coordinator
Bureau of Family Health and Nursing
Services
Department of Public Health and
Social Services
P.O. Box 2816
Agana, Guam 96910
9-011-671-734-7116
9-011-671-734-7097 FAX

HAWAII
Nancy Kuntz, M.D.
Chief
Family Health Services Division
Hawaii Department of Health
1250 Punchbowl Street, Room 216
Honolulu, HI 96813
(808) 733-9017
(808) 733-8369 FAX

IDAHO
Roger Perotto
Chief Clinical/Preventive Health Services
Idaho Department of Health/Welfare
450 West State Street
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5930
(208) 332-7346 FAX

ILLINOIS
Stephen E. Saunders, M.D., M.P.H.
Chief, Division of Family Health
Illinois Department of Public Health
535 West Jefferson Street
Springfield, IL 62761
(217) 782-2736
(217) 557-2595 FAX

INDIANA
Judith Ganser, M.D., M.P.H.
Medical Director
Division of Maternal and Child Health
Indiana State Department of Health
2 North Meridian Street, Suite 700
Indianapolis, IN 46204
(317) 233-1240
(317) 233-1299 FAX

IOWA
M. Jane Borst, R.N., M.A.
Chief
Bureau of Family Services
Iowa Department of Public Health
321 E. 12th St.
Des Moines, IA 50319-0075
(515) 281-4911
(515) 242-6384 FAX

KANSAS
Cassie Lauver, A.C.S.W.
Director
Bureau for Children, Youth and Families
Kansas Dept.of Health and Environment
Landon State Office Building
900 S.W. Jackson, 10th Floor
Topeka, KS 66612-1290
785-296-1310
785-296-8626 FAX

KENTUCKY
Steve Davis, M.D.
Dir., Div. Adult and Child Health
KY Dept. for Public Health
275 East Main Street
Frankfort, KY 40621
502-564-4830
502-564-8389 FAX

LOUISIANA
Joan Wightkin, M.P.H.
Administrator
Maternal and Child Health Section
Office of Public Health
Louisiana Dept. of Health and
Hospitals
325 Loyola Avenue, Room 612
New Orleans, LA 70160
504-568-5073
504-568-8162 FAX

MAINE
Valerie J. Ricker, MSN, MS
Director, Family Health Programs
Maine Department of Human Services
State House - Station 11
151 Capitol Street
Augusta, ME 04333-011
207-287-5180
207-287-4631 FAX

MARIANA ISLANDS
Josephine Sabian
Director, Public Health Commonwealth Hlth. Center
Department of Health and
Environmental Services
P.O. Box 409 CK
Saipan, MP 96950
011-670-234-8950
011-670-234-8930 FAX

MARSHALL ISLANDS
Justina Langidrik, MPH
Assistant Secretary, Primary Health Care Ministry of Health & Environment
P.O. Box 16
Majuro, Marshall Islands 96960
011-692-625-3355
011-692-625-3432 FAX

MARYLAND
Russell W. Moy, M.D.
Director, Maternal Health & Family Planning
Maryland Department of Health/Mental Hygiene
201 West Preston Street
Room 318
Baltimore, MD 21201
410-767-6721
410-333-5233 FAX

MASSACHUSETTS
Deborah Klein Walker, Ed.D.
Assistant Commissioner
Bureau of Family and Community Health
Massachusetts Department of Public Health
250 Washington Street, 5th Floor
Boston, MA 02108-4619
617-624-6090
617-624-6062 FAX

MICHIGAN
Virginia Harmon
Michigan Department of Community Health
3423 N. Logan/Martin L. King, Jr. Blvd.
P.O. Box 30195
Lansing, MI 48909-0195
517-335-9371
517-335-8560 FAX

MICRONESIA
Sizue Yoma, R.N., B.S.N.
MCH/CSHN Coordinator
Department of Health Services
Government of the Federated States of Micronesia
P.O. Box PS 70
Palikir Station
Pohnpei, FM 96941
011-691-320-2619
011-691-320-5263 FAX

MINNESOTA
Jan Jernell, MPH
Director
Division of Family Health
Minnesota Department of Health
717 Delaware Street, S.E.
P.O. Box 64882
St. Paul, MN 55164-8953
651-281-9883
651-215-8953 FAX

MISSISSIPPI
Hazel Gaines, RN, MS
Director, Women's Health Bureau
Mississippi State Department of Health
2423 North State Street
P.O. Box 1700
Jackson, MS 39215-1700
601-960-7464
601-960-6104 FAX

MISSOURI
Glenda Miller
Director
Div. of Maternal, Child and Family Health
Missouri Department of Health
930 Wildwood Drive, PO Box 570
Jefferson City, MO 65102-0570
573-751-6174
573-526-5348 FAX

MONTANA
JoAnn Walsh Dotson, MSN, RN
Chief, Family and Community Health Bureau
Montana Department of Public Health
and Human Services
PO Box 202951
1400 Broadway
Helena, MT 59620
406-444-4743
406-444-2606 FAX

NEBRASKA
Paula Eurek
Administrator, Division of Family Health
Nebraska Department of Health
301 Centennial Mall South
P.O. Box 95044
Lincoln, NE 68509-5044
(402) 471-3980
(402) 471-7049 FAX

NEVADA
Judy Wright
Bureau Chief
Family Health Services Bureau
Nevada State Health Division
505 East King Street, Room 200
Carson City, NV 89701-4792
(775)684-4285
(702) 684-4245 FAX

NEW HAMPSHIRE
Charles Albano
Chief
Bureau of Maternal and Child Health
New Hampshire Division of Public Health Services
6 Hazen Drive
Concord, NH -3301-6527
(603) 271-4516
(603) 271-3827 FAX

NEW JERSEY
Celeste F. Wood, M.A.
Director, Community Health Services
New Jersey Department of Health
Capital Center Building, 6th Floor
50 East State Street, CN364
Trenton, NJ 08625-0364
(609) 984-1384
(609) 292-3580 FAX

NEW MEXICO
Marilyn Sakara
Manager, Children's Medical Services
Maternal and Child Health Bureau
Public Health Division
New Mexico Department of Health
1190 St. Francis Drive
Sante Fe, NM 87502
(505) 827-2350
(505) 827-1697 FAX

NEW YORK
George Diferdanado, M.D., M.P.H.
Director, Division of Family and Local Health
New York State Department of Health
Empire State Plaza
Corning Tower Building, Room 780
Albany, NY 12237
(518) 473-7922
(518) 474-2015 FAX

NORTH CAROLINA
Kevin Ryan, MD, MPH
Chief, Women's & Children's
Health Section
North Carolina Department of
Health and Human Services
P.O. Box 29597
Raleigh, NC 27626-0597
(919) 715-3400
(919) 715-3410 FAX

NORTH DAKOTA
Sandra Anseth, R.N.
Director
Division of Maternal and Child Health
North Dakota State Department of Health
State Capitol Building
600 East Boulevard Avenue
Bismarck, ND 58505-0200
(701) 328-4532
(702) 328-1412 FAX

OHIO
Kathryn K. Peppe, R.N., M.S.
Chief
Division of Maternal and Child Health
Ohio Department of Health
246 North High Street, 7th Floor
P.O. Box 118
Columbus, OH 43266-0118
(614) 466-3263
(614) 728-3616 FAX

OKLAHOMA
Edd D. Rhoades, MD, MPH
Chief, Maternal and Child Health Service
Oklahoma State Department of Health
1000 N.E., 10th Street
Oklahoma City, OK 73117-1299
(405) 271-4477
(405) 271-1011 FAX

OREGON
Donaldo Dodson, RN, MPH
Acting Assistant Administrator
Center for Child and Family Health
Oregon State Health Division
800 N.E. Oregon, #21, Suite 850
Portland, OR 97232
(503) 731-4398
(503) 731-4083 FAX

PALAU
Juaquina Ulenghong
Acting MCH/CSHN Coordinator
Ministry of Health Services
Palau National Hospital
P.O. Box 6027
Koror, Palau 96940
9-011-680-488-2420
9-011-680-488-3115 FAX

PENNSYLVANIA
Daniel Brant, MSW
Acting Director
Bureau of Family Health
Pennsylvania Department of Health
P.O. Box 90
Harrisburg, PA 17108
(771) 787-7192
(771) 772-0323 FAX

PUERTO RICO
Roberto Varela-Flores, M.D., M.P.H.
Director
Maternal and Child Health
Commonwealth of Puerto Rico
Department of Health
Call Box 70184
San Juan, PR 00936-8184
(787) 274-5678
(787) 274-5523 FAX

RHODE ISLAND
William Hollinshead, M.D., M.P.H.
Medical Director
Division of Family Health
Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908-5097
(401) 277-2312
(401) 277-1442 FAX

SOUTH CAROLINA
Marie C. Meglen, M.S., C.N.M.
Director
Bureau of Maternal and Child Health
South Carolina Department of Health
and Environmental Control
1751 Calhoun St.
P.O. Box 101106
Columbia, SC 29211
(803) 898-0872
(803) 898-0380 FAX

SOUTH DAKOTA
Colleen Winter, RN, BSN
Administrator, Offfice of Family Health
South Dakota Department of Health
615 East 4th Streeet
Pierre, SD 57501-3185
(605) 773-3737
(605) 773-5509 FAX

TENNESSEE
Mary J. Dewey, B.S., M.A., M.P.A.
Director
Maternal and Child Health
Tennessee Department of Health
425 Fifth Avenue North, 5th Floor
Cordell Hull Building
Nashville, TN 37247-4701
(615) 741-7353
(615) 741-1063 FAX

TEXAS
Jack Baum, MBS
Associate Commisioner
Associateship of Health Care Delivery
Texas Department of Health
1100 West 49th Street
Austin, TX 78756-3199
(512) 458-7321
(512) 458-7358 FAX

UTAH
Kathleen Glasheen, R.N., M.S., CPNP
Bureau Director,
Community and Family Health Services
Utah Department of Health
P.O. Box 142001
Salt Lake City, UT 84114-2001
(801) 538-6869
(801) 538-9409 FAX

VERMONT
Patricia Berry, MPH
Director, Div. Of Community Public
Health
Vermont Department of Health
108 Cherry Street
P.O. Box 70
Burlington, VT 05402-0070
802-863-7347
802-863-7229 FAX

VIRGINIA
Janice Hicks, PhD
Policy Analyst
Office of Family Health Services
Virginia Department of Health
1500 East Main Street, 1st Floor
Suite 104
Richmond, VA 23219
(804) 371-4125
(804) 692-0184 FAX

VIRGIN ISLANDS
Mavis L Matthew, M.D., M.P.H.
MCH and CSHN Director
U.S. Virgin Islands Department of Health
Charles Harwood Hospital
3500 Estate Richmond
St. Croix, Virgin Islands 00820-4370
(809) 773-1311
(809) 773-5884 FAX

WASHINGTON
Maxine Hayes, M.D., M.P.H.
Assistant Secretary
Division of Community and Family Health
Department of Health
P.O. Box 47830
Olympia, WA 98504-7830
(360)236-3721
(360) 664-4500 FAX

WEST VIRGINIA
Patricia Moss, M.S.W.
Director
Office of Maternal and Child Health
WV Department of Health
1411 Virginia Street, East
Charleston, WV 25301
(304) 558-5388
(304) 558-2183 FAX

WISCONSIN
Millie Jones
MCH Section Chief
Bureau of Public Health
Wisconsin Division of Health
1414 East Washington Avenue, Room 167
Madison, WI 53704-3043
(608) 266-2684
(608) 267-3824 FAX

WYOMING
Phyllis Sherard, MPH
MCH Manager
Division of Public Health
Wyoming Department of Health
Hathaway Building 465
Cheyenne, WY 82002-0710
(307) 777-7942
(307) 777-5402 FAX

APPENDIX J - Project Personnel Allocation Table

Project Title: _____ Project Director: _____

Budget Period: _____ to _____ Project Year: _____ State: _____
(1, 2, or 3)

Objectives and Approaches	Staff and Consultants by Title; Include Person Days for Each									